POSIT

Name of Client_____Date_____

	DSS Substance Abuse Screening Instrument	YES	NO
1	Did you get into trouble because you use drugs or alcohol at school?		
2	Have you accidentally hurt yourself or someone else while high on alcohol or drugs?		
3	Do you miss out on activities because you spend too much money on drugs or alcohol?		
4	Do you ever feel that you are addicted to alcohol or drugs?		
5	Have you started using more and more drugs or alcohol to get the effect you want?		
6	Do you ever leave a party because there is no alcohol or drugs?		
7	Do you have a constant desire for alcohol or drugs?		
8	Have you had a car accident whole high on alcohol or drugs?		
9	Do you forget things you did while drinking or using drugs?		
10	During the past month have you driven a car while you were drunk or high?		
11	Does alcohol or drug use cause your moods to change quickly like from happy to sad or vice versa?		
12	Do you miss school or arrive late for school because of your alcohol or drug use?		
13	Do your family or friends ever tell you that you should cut down use on your drinking or drug use?		
14	Do you have serious arguments with friends of family members because of your drinking or drug use?		
15	Does your alcohol or drug use ever make you do something you would not normally do – like breaking rules, missing curfew, breaking the law or having sex with someone?		
16	Do you have trouble getting along with any of your friends because of your alcohol of drug use?		
17	Do you ever feel you can't control your alcohol or drug use?		
	TOTALS		

DSS Representative Signature_____